Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

KUTINA DENTAL OFFICE 3820 6TH ST. GREAT BEND, KS. 67530 620-792-2114

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ___/___/_____SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ___/___/_____

SSN# _____

Relationship: _____

About Dr.Kutina:
Doctor of Dental Surgery University of Missour-Kansas City School of Dentistry
Member:
American Dental Association
Kansas Dental Association
Member of Spear Faculty Club
Alumni :
L. D. Pankey Institute for Advanced Dental Education

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at:[ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?

_____ _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ___/___/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ___/___/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

CONFIDENTIAL

Time 12:57 PM

Kutina Dental Office

Date 7/3/2018

Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	

Additional medications:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No		
Do you use tobacco?	○ Yes ○ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No
Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No
Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No
Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No	Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No
Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No
Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No
Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Psychiatric Care	○ Yes ○ No						

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Dental History

Name of previous dentist:

Date of last dental exam:

Do you like your smile? Yes No

Do you like the color and shape of your teeth? Yes No

Have you ever received oral hygiene instructions regarding the care of your teeth? Yes No

Do your gums bleed while brushing or flossing? Yes No

Do you feel pain in any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had any head, neck, or jaw injuries? Yes No

Have you experienced any of the following problems in your jaw?

Clicking? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing? Yes No

Difficulty chewing? Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had any difficult extractions? Yes No

Have you ever had any orthodontic treatment? Yes No

Sleep History

Have you ever been diagonsed with sleep apnea? Yes No

Have you ever been diagnosed with restless sleep syndrome? Yes No

Have you ever had a sleep test? Yes No

Do you wear a CPAP machine? Yes No

Do you snore? Yes No

Have you had your tonsils and/or adenoids removed? Yes No

Do you have any other concerns? Please describe.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____